Health Reimbursement Arrangement Claim Form

Your Name:	Employer:
Email Address:	Date:

Reimbursement requests must not have been previously reimbursed nor are you seeking reimbursement from any other source. Documentation provided must include the name of the provider, date of service, requested reimbursement amount, type of service, Rx number and the name of the prescription (if appropriate).

Patient Name	Date of Service	Provider Name	Type of Service	Requested Amount
				$
				$
				$
				$
				$
			Total Requested	$

Participant Authorization:

I hereby certify that the reimbursement requests above are for items or services covered under my employer's plan and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from any other source. I also understand that RSS Agency, Inc., its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. This request cannot be accepted without participant's signature:

Employee Signature:_____ Date:_____

RSS AGENCY

RSS Agency
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